

Kansas Medical Assistance Program Prior Authorization Request Form for Non-Preferred Drugs

FAX completed form to the Prior Authorization Unit @ 1-800-913-2229 (274-5956 Topeka)

This includes all generic equivalents

Adjunct Antiepileptics			
Preferred		Non-preferred	
<i>This includes all generic equivalents</i>		<i>This includes all generic equivalents</i>	
Drug Covered		Prior Authorization Required	
Pregabalin	Lyrica®	Zonegran	Zonisamide®
Levetiracetam	Keppra®	Gabitril	Tiagabine®
Gabapentin	Neurontin®		

**** Indicates REQUIRED information**

****CONSUMER NAME:** _____ ****Medicaid Number:** _____

****PHARMACY NAME:** _____ ****Medicaid Number:** _____

****Phone Number:** _____ ****Fax Number:** _____ ****NDC:** _____

****PRESCRIBING PHYSICIAN NAME:** _____ ****Medicaid Number:** _____

****Phone Number:** _____ ****Fax Number:** _____

**** Indicate:** Non-Preferred Drug prescribed: _____ Other: _____

**** Check:** the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:

☐ Medical intolerance to Preferred Drug. **Provide clinical symptoms:** _____

☐ Inadequate response to Preferred Drug.

**** Indicate:** Preferred Drug tried: _____ Length of trial: _____

☐ Absence of appropriate formulation or indication of the drug. Please specify: _____

☐ Pre-existing or co-morbid condition exists that contraindicates the use of a preferred drug. Please specify: _____

****Prescribing Physician's signature:** _____ **Date:** _____

If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied. **For questions related to Prior Authorization, contact 800-285-4978, option #3 or 274-5499, in Topeka.** General support is provided at 800-933-6593. For questions related to pharmacy issues, contact the Pharmacy Help Desk toll-free at 866-405-5200.